Department of Management & Budget
Office of Retirement Services
www.michigan.gov/ors (800) 381-5111
P.O. Box 30171
Lansing MI 48909-7671

Retiree Group Insurance Eligibility Notice

For State Defined Contribution Members

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN
MAILING ADDRESS	DATE OF BIRTH
CITY, STATE, ZIP CODE	HOME TELEPHONE ( )

I have notified my employer of my intent to terminate from state employment. My termination date is _____, 20____. I have met the age and service requirements and wish to enroll in the insurance programs effective the first of the month after my last day on the payroll, or the first of the month following the receipt of this form by the Office of Retirement Services (ORS), whichever is later. I have attached the completed insurance enrollment form(s) and life insurance beneficiary designation. I understand I will be billed monthly for my share of the insurance premium.

EMPLOYEE'S SIGNATURE		DATE
SPOUSE'S NAME (WRITE "NONE" IF NOT MARRIED)	SPOUSE'S SIGNATURE	DATE

Return this completed form with attachments to:

Office of Retirement Services
P.O. Box 30171
Lansing MI 48909-7671

Keep a copy for your records.

To be completed by ORS – Defined Contribution Use Only

☐ REGULAR RETIREMENT ☐ DCH FACILITY CLOSURE ☐ CONSERVATION OFFICER ☐ COVERED MEMBER	INSURANCE SUBSIDY _____ YEARS OF SERVICE X 3% = _____%	
ELIGIBLE FOR IMMEDIATE INSURANCE BENEFITS? ☐ YES ☐ NO	YEARS OF SERVICE	AGE ON DATE OF SEPERATION
INFORMATION VERIFIED BY (PLEASE PRINT)		TELEPHONE NUMBER

R517G (Rev. 3/2008)
Authority: 1943 P.A. 240, as amended